VSH Futures
Care Management Workgroup
Subgroup on Client Movement through the System of Care
(Includes edits recommended by the VSH Advisory Committee on 1/23/06)
January 23, 2006
Draft #4

Principles that Guide the Movement of Clients through the System

1. Placement decisions or recommendations, and the authority to effect them reside with and are made by the client-clinician team, starting at the point of establishing a client-provider relationship or writing emergency evaluation papers.

1.10 Clients have an inherent right to choose where to live and/or receive care. That choice may be limited by safety needs of the client and the community, and by the availability of resources.

1.11 Placement or movement of clients observes the principle of using the least restrictive and most integrated settings that are consistent with safety needs. Placement decisions follow the spirit and letter of state and federal law as expressed in the Olmstead ruling.

1.12 Uniform procedures are in place to ensure that as clients enter and move from one part of the system to another, they are informed of their legal status and rights, and receive the necessary assistance to exercise them. Assistance is offered in an atmosphere and manner that supports understanding and thoughtful deliberation about legal issues.

1.13 The receiving facility, program, or clinician has the authority to determine that they lack the capacity to serve a particular client based on factors such as adequacy of skills or resources. When a team turns down a referral, they fully articulate the logistical and/or clinical factors driving the decision, and they remain actively engaged with the other parts of the system in an ongoing decision making process until resolution and placement is achieved.

1.20 The care system requires information technology sufficient to enable operation as a single virtual facility. This includes but is not limited to: one electronic medical record rather than a separate paper record at each physical facility, access across the system to real-time information on resource availability, single-point bed manager function active 24/7, ability to de-identify and aggregate data for outcome studies, and telemedicine for inter-system consultation.

1.21 A uniform plan of care goes with the client through the different levels of care, providing continuity across all settings and over time. Treatment teams change membership to meet the client's needs as clinical situations change. They include at a minimum the client (or the client's agent) and the clinician(s) involved in ongoing care and/or transfers.

1.22 Access to services and movement between all facilities is timely and is based on unified admission/exit criteria, protocols, policies, forms, and referral communications.

1.23 The state leads a centralized resource management function for the system that includes the ability to meet critical census demands with temporary emergency placements at facilities in the community. Such central authority is exercised only when teams are unable to come to a decision or resolve a conflict (see conflict resolution protocol) within a time frame that is efficient for the system, safe for the client, and in the best interest of all clients in the system.

1.24 The system is adequately designed to ensure: control by the client or client's agent over who has access to the medical record; protection of the records' confidentiality from private, governmental, or criminal concerns; and prevention of the records' loss from system failures or natural disasters.

1.25 The care management system is designed to include oversight by members of the community.

2. In the integrated system, risk management is based on shared risk among hospitals, designated agencies, private providers and the state. This is achieved through joint decision making. No one group makes unilateral decisions or assumes risk individually. Reduced risk is a consequence of shared risk

3. The legal process affecting movement of clients functions in a timely manner. Timely hearings serve a client's right to due process and support clinical goals.

4. Managing quality of care is achieved through a system of defined standards, and protocols or guidelines for attaining them. The system measures success at meeting the standards, makes ongoing measurement of deviation from the standards, and provides analysis of the reasons for those deviations. This measurement provides the basis for improving the system and advocating for needed resources. Outcome studies are used to evolve and improve the standards.